The Beckwith-Wiedemann syndrome (BWS) is the most common and the best-known congenital overgrowth syndrome. It was named after Beckwith who in 1963 described three unrelated patients with exomphalos, hyperplasia of the kidneys and pancreas, and adrenal cytomegaly. Wiedemann in 1964 reported a familial form of omphalocele with macroglossia. The incidence is estimated to be about 1 in 13,700 births.

**GENETICS/BASIC DEFECTS**

1. Genetics of BWS: complex
   a. Pedigree data
      i. Sporadic (85%)
      ii. Familial (15%): autosomal dominant inheritance with variable expressivity, incomplete penetrance, and preferential maternal transmission
   b. Karyotypic data
      i. Chromosome rearrangements influenced by the parent of origin (2%)
         a) Paternally derived 11p15.5 duplications exhibiting atypical clinical features as well as a significant risk of developmental delay
         b) Maternally derived translocations and inversions exhibiting typical features of BWS
      ii. Normal karyotype (98%)
   c. Molecular data: BWS is caused by alterations in growth regulatory genes on chromosome region 11p15.5, which is subjected to genomic imprinting (an epigenetic mechanism in which gene expression is altered according to the parental origin of the allele)

2. Pathogenesis
   a. Imprinted genes have been implicated in the pathogenesis of both familial and sporadic BWS
   b. A subgroup of BWS patients has loss of methylation at a differentially methylated region (KvDMR1) within the KCNQ1 gene centromeric to the IGF2 and H19 genes
   c. Maternally expressed 11p genes
      i. P57KIP2 (also known as CDKN1C, a cation-independent cyclase): a candidate for a maternally expressed growth inhibitory gene in BWS
         a) Germline mutations detected in >40% of familial cases
         b) Mutations infrequent (<5%) in sporadic cases
      ii. H19: a maternally expressed gene encoding a biologically active nontranslated mRNA that may function as a tumor suppressor. Deletion of H19 or transposition from its usual position relative to IGF2 disrupts normal imprinting
      iii. KCNQ1 (also known as KvLQT1): serves as an imprinting center, disruption of which could affect transcription and DNA replication through an effect on chromatin structure
   d. Paternally expressed 11p genes
      i. IGF2 (the gene for insulin-like growth factor-2): a paternally expressed and maternally imprinted embryonic growth factor. Many sporadic cases show loss of imprinting of IGF2 resulting in biallelic expression
      ii. KCNQ1OT1 gene (also known as LIT1): the unmethylated paternal allele of KvDMR1 permits transcription of the antisense transcript KCNQ1OT1 and silencing of the KCNQ1 and CDKN1C genes
   e. Effect of multiple genes: combination of increased expression of paternally expressed growth promoter genes such as IGF2 and loss of maternally expressed growth suppressor genes in some patients with paternal uniparental disomy of 11p15
   f. Uniparental disomy (mosaic paternal isodisomy) for the band 11p15.5 (10–20% of sporadic cases)
      i. Two paternally derived copies of chromosome 11p15 and no maternal contribution for that chromosome region
      ii. Resulting from postzygotic mitotic recombination and mosaic paternal isodisomy
      iii. All patients with uniparental disomy exhibit somatic mosaicism

**CLINICAL FEATURES**

1. Variable phenotypic expression
2. Prenatal and postnatal overgrowth (gigantism) (cardinal feature)
   a. Large or above normal size baby at birth
   b. Eventual somatic gigantism in most cases
   c. Advanced bone age
   d. Hemihyperplasia or hemihypertrophy (13%)
3. Performance
   a. Varying intelligence
      i. Normal
      ii. Mild-moderate mental retardation from undetected hypoglycemic episodes during infancy
   b. Seizures in some cases
4. Craniofacial features
   a. Macroglossia (cardinal feature)
      i. Chronic alveolar hypoventilation
      ii. Anterior open bite
   b. Ear-lobe grooves or indented ear lesions on the posterior rim of the helix or concha
   c. Nevus flammeus
   d. Midfacial hypoplasia
   e. Prominent occiput
5. Abdominal wall defect
   a. Omphalocele (cardinal feature)
   b. Umbilical hernia
   c. Diastasis recti
6. Gastointestinal anomalies
   a. Malrotation anomalies
   b. Dome-shaped defect of the diaphragm
7. Visceromegaly
   a. Hepatomegaly (frequent)
   b. Nephromegaly (frequent)
   c. Cardiomegaly
   d. Occasional clitoromegaly
   e. Hyperplastic pancreas, bladder, uterus, and thymus
8. Neoplasms (7.5%)
   a. Benign tumors
      i. Adrenal adenoma
      ii. Carcinoid tumor
      iii. Fibroadenoma
      iv. Fibrous hamartoma
      v. Ganglioneuroma
      vi. Myxoma
   b. Malignant tumors
      i. Wilms tumor (most frequent)
      ii. Adrenocortical carcinoma
      iii. Hepatocellular carcinoma
      iv. Glioblastoma
      v. Neuroblastoma
      vi. Rhabdomyosarcoma
      vii. Malignant lymphoma
      viii. Pancreatoblastoma
      ix. Teratoma
9. Additional features
   a. Polyhydramnios
   b. Prematurity
   c. Enlarged placenta
   d. Hemangioma
   e. Other renal anomalies
      i. Medullary dysplasia
      ii. Duplicated collecting system
      iii. Nephrocalcinosis
      iv. Medullary sponge kidney
      v. Cystic changes
      vi. Diverticula
10. Adult phenotype
    a. Hemihiperplasia
    b. Prominent jaw
    c. Enlarge tongue
    d. Ear creases and pits
    e. Enlarged kidneys and other abdominal organs
    f. Normal height

DIAGNOSTIC INVESTIGATIONS
1. Transitory neonatal hypoglycemia (spontaneous regression during the first 4 months of life) (63%)
2. Neonatal polycythemia (20%)
3. Hypercholesterolemia, hyperlipidemia, hypothyroidism, thyroxine-binding globulin deficiency: rare occurrence
4. Periodic abdominal ultrasonography for organomegaly and embryonal tumors, followed by MRI or CT if indicated
5. Radiography
   a. Advanced bone age
   b. Chest radiography to rule out rare neural crest tumors such as thoracic neuroblastoma
6. Echocardiography for suspected cardiac abnormality
7. Chromosome analysis (high resolution and FISH studies)
   a. Normal chromosomes in most patients
   b. Chromosome abnormalities involving 11p15 in ≤1% of cases
      i. Paternally derived 11p15 duplication
      ii. Maternally derived translocations and inversions
8. Molecular analysis
   a. Paternal uniparental disomy (UPD) of 11p15 in multiple tissues (10–20%)
      i. Restriction fragment length polymorphism (RFLP) analysis of multiple 11p15 loci
      ii. Methylation studies of multiple imprinted genes on 11p15
   b. Mutation analysis: P57KIP2 (5–10%) (screen for mutation by heteroduplex/SSCP analysis, followed by sequence of P57KIP2 exons)

GENETIC COUNSELING
1. Recurrence risks
   a. Probably a low recurrence risk in cases of negative family history, normal karyotype, and absence of identifiable molecular etiology
   b. Up to 50% of recurrence risk in cases of positive family history and normal karyotype
   c. Up to 50% recurrence risk in cytogenetically detected paternal 11p15 translocation or inversion
   d. An undetermined recurrence risk in cytogenetically detected maternal 11p15 translocation or inversion
   e. A very low recurrence risk in cases of paternal 11p15 uniparental disomy as this event arises from a postzygotic somatic recombination
   f. Up to 50% recurrence risk if a P57KIP2 mutation is present in a parent (usually maternally transmitted)
2. Prenatal diagnosis
   a. Maternal serum alpha fetoprotein screening: may be elevated in a fetus with omphalocele
   b. Prenatal Ultrasonography
      i. Fetal overgrowth (macrosomia)
      ii. Polyhydramnios
      iii. Enlarged placenta
      iv. A long umbilical cord
      v. MacroGLOSSIA
      vi. Distended abdomen
      vii. Abdominal wall defects
      viii. Organomegaly
      ix. Renal anomalies
     x. Cardiac anomalies
   c. Cytogenetic studies
      i. Possible if a cytogenetic abnormality has been identified in the proband and one parent
      ii. To identify translocations, inversions, and duplications involving 11p15
   d. Molecular analysis
      i. Uniparental disomy
      ii. Mutation analysis of P57KIP2 provided the mutation is documented in the previously affected child
3. Management
   a. Early detection and close monitoring for hypoglycemia to reduce the risk of central nervous system complications
   b. Partial tongue resection for cosmetic purpose and to relieve severe airway obstruction
   c. Surgical risks related to hypoglycemia or difficulty in intubation secondary to macroglossia
   d. Management of abdominal wall defects, gastrointestinal malformations, and renal anomalies
   e. Orthopedic follow-up of hemi-hyperplasia
   f. Management of structural renal abnormalities
   g. Management of embryonal neoplasms

REFERENCES
Fig. 1. Five infants with BWS showing hemangioma, macroglossia and umbilical hernia.
Fig. 2. An infant with BWS showing macroglossia, ear crease, and umbilical hernia.

Fig. 3. An infant with BWS and a large omphalocele requiring surgical intervention.

Fig. 4. An infant with BWS prior to partial glossectomy.

Fig. 5. A young adult with BWS showing macroglossia and post-surgical status of umbilical and inguinal hernia repairs.
Behcet Disease

In 1937, Behçet first described three patients with oral and genital ulceration and hypopyon. It is most common in the Middle and Far East with a prevalence of 7 to 8 per 100,000 people, whereas in the United States the prevalence is estimated at 4 per 1,000,000 people.

GENETICS/BASIC DEFECTS
1. A complex multisystem inflammatory disease of unknown cause
2. Considered a relapsing and remitting vasculitis of the small- to medium-sized vessels with following protein manifestations
   a. Aphthous stomatitis
   b. Genital ulceration
   c. Uveitis
   d. Synovitis
   e. Gastrointestinal lesions
   f. Cutaneous lesions
   g. Central nervous system lesions
   h. Cardiac lesions
   i. Vessel lesions
3. Immunopathogenic aspects of Behcet disease
   a. Neutrophil activation
   b. Cellular and humoral immunity
   c. Antigenic stimuli
      i. Herpes simplex virus
      ii. Streptococci and superantigens
      iii. Heat shock proteins (65 kDa, β-crystallin)
   d. Genetic predisposition to HLA-B51 and antigen presentation
   e. Retinal-S antigen and HLA-B51 as autoantigens
   f. Vascular disease and antiendothelial cell antibodies
   g. Severity and sex: more severe in men

CLINICAL FEATURES
1. Highly variable clinical course with recurrences and remissions
2. Recurrent attacks of oral, genital, ocular, and skin lesions
   a. Oral aphthous ulcers
      i. Keystones to diagnosis of Behcet disease according to the classification criteria
      ii. Often an initial presenting sign
      iii. Occurring on the buccal mucosa, tongue, gingiva and the soft palate area
      iv. Minor aphthous ulcers: superficial with a diameter of 2–6 mm, appearing as multiple lesions, and developing within 1–2 days. They heal without scarring within 7–10 days and recur at various frequencies
      v. Major aphthous ulcers: deeper and painful lesions leaving scars after healing
   b. Genital ulcers
      i. Women: located on the vulva, vagina, cervix uteri
      ii. Men: located on the prepuce and scrotum
      iii. Lesions resembling the oral aphthae but tend to be deeper and leaving scars
   c. Ocular lesions (70–85%)
      i. Generally follow the genital and oral ulceration by a few years
      ii. Characterized by severe vasculitis with arterial and venous occlusions
      iii. Hypopyon (presence of leukocytes in the anterior chamber of the eye)
      iv. Uveitis
      v. Hemorrhagic and exudative retinal lesions (retinitis)
      vi. Marked vitritis
      vii. Choroiditis
   d. Skin lesions
      i. Pustular vasculitic cutaneous lesions: may evolve as lesions of small vessel necrotizing vasculitis from a neutrophilic vascular reaction to a lymphocytic perivascular reaction
      ii. Erythema nodosum-like lesions: usually occurring on the lower extremities but can be seen on the arms, neck, and face
   e. Pseudofolliculitis
   f. Papulopustular lesions: neutrophil-induced, vessel-based reaction
   g. Acneiform nodules
3. Articular manifestations
   a. Recurrent seronegative arthritis
      i. Common findings
   b. Monoarthritis
   c. Polyarthritis
4. Gastrointestinal manifestations
   a. Ulcerative lesions most frequently occurring in the terminal ileum, caecum, stomach, and intestine
   b. Symptoms
      i. Abdominal pain
      ii. Diarrhea
      iii. Melena
      iv. Perforation
5. CNS manifestations (about 1% of patients)
   a. Headaches
   b. Meningitis
c. Meningoencephalitis
d. Cranial nerve palsies
e. Peripheral nerve involvement with vasculitis
f. Cerebellar ataxia
g. Hemiplegia
h. Benign intracranial hypertension
i. Neurologic deficits
j. Cerebral aneurysm
k. Cerebral vasculitis and ischaemic stroke: unusual
l. Personality changes and depression
m. Dementia
n. Hearing and vestibular disturbances

6. Pulmonary manifestations
a. Tracheobronchial ulcerations
b. Pleurisy
c. Embolism
d. Pulmonary arterial aneurysms
e. Pneumonitis
f. Fibrosis

7. Renal involvement: rare
a. Glomerulonephritis
b. Systemic amyloidosis

8. Cardiac manifestations
a. Intracardiac thrombosis
b. Myocardial infarction
c. Pericarditis
d. Endocarditis

9. Vascular manifestations
a. Superficial thrombophlebitis
b. Deep thrombophlebitis
c. Small vessel vasculitis
d. Aneurysm

10. Criteria for clinical diagnosis of Behcet disease, proposed by O’Duffy and Goldstein in 1976, require the presence of recurrent oral or genital aphtha along with two additional systemic findings for diagnosis and only one for the diagnosis of the incomplete form
a. Criteria
i. Aphthous stomatitis
ii. Aphthous genital ulceration
iii. Uveitis
iv. Cutaneous “pustular” vasculitis
v. Synovitis
vi. Meningoencephalitis
b. Diagnosis: at least three criteria present, one being recurrent aphthous ulceration

11. The International Study Group criteria were published in 1990 to include positive Pathergy test as one of the criteria to establish the diagnosis of Behcet disease:
a. Recurrent oral ulceration: minor aphthous, major aphthous, or herpetiform ulceration observed by physician or patient that recurred at least three times in one 12-month period

b. Plus 2 of the following criteria (findings applicable only in absence of other clinical explanations)
   i. Recurrent genital ulceration: aphthous ulceration or scarring observed by physician or patient
   ii. Eye lesions: anterior uveitis, posterior uveitis, or cells in vitreous on slit lamp examination; or retinal vasculitis observed by ophthalmologist
   iii. Skin lesions: erythema nodosum observed by physician or patient, pseudofolliculitis or papulopustular lesions; or acneiform nodules observed by physician in post-adolescent patients not receiving corticosteroid treatment
   iv. Pathergy test (a nonspecific pustule that is an inflammatory reaction to needle pricks in approximately 40% of patients, especially during the exacerbation period): Pathergy test is positive when pricking a sterile needle into the patient’s forearm results in an aseptic erythematous nodule or pustule that is more than 2 mm in diameter at 24–48 hours

DIAGNOSTIC INVESTIGATIONS
1. Positive skin pathergy
2. Laboratory findings
   a. Acute-phase response
      i. Raised erythrocyte sedimentation rate
      ii. Increased serum levels of C-reactive protein
      iii. Elevated plasma complement components, such as C3, C4, C9, and factor B
   b. Disease exacerbations
      i. Elevated IgG, IgA, IgM
      ii. Elevated C-reactive protein
      iii. Elevated α2-globulin
   c. Interleukin (IL)-8 as a serological marker
3. HLA typing
4. Fluorescein angiography, color Doppler imaging and fundoscopic examination to detect retinal features
5. MRI and CT scan to detect the neurologic lesions
6. Histopathological features
   a. Pathergy lesions
      i. Leucocytoclastic vasculitis
      ii. Neutrophilic vascular reaction
      iii. Polymorphonuclear leucocyte infiltration
   b. Erythema nodosum-like lesions
      i. Neutrophilic vascular reaction or vasculitis in the dermis and subcutaneous tissue
      ii. Perivascular lymphocytic dermal inflammation
   c. Common histopathological lesions in all organ systems
      i. Vasculitis
      ii. Thrombosis
      iii. Perivascular infiltrates of lymphomononuclear cells
      iv. Neutrophilic vascular reaction
   d. Early cutaneous lesions: neutrophilic vascular reaction or leucocytoclastic vasculitis
   e. Late cutaneous lesions: lymphocytic perivasculitis

GENETIC COUNSELING
1. Recurrence risk
   a. Patient’s sib: not increased
3. Management:
   a. Mucocutaneous lesions
      i. Topical corticosteroids: useful for oral and genital ulcers
      ii. Colchicine: beneficial effects on the mucocutaneous symptoms, presumably by inhibiting neutrophil function
      iii. Treatment with thalidomide: effective for oral and genital ulcers and pseudofolliculitis
   b. Gastrointestinal lesions
   c. Ocular lesions
      i. About 25% of patients eventually develop blindness despite therapeutic intervention
      ii. Topical mydriatic agents and corticosteroid drops: given for attacks of anterior uveitis
      iii. Colchicine: prescribed to prevent both anterior and posterior uveitis because of its high degree of efficacy and relatively low toxicity
      iv. Topical injection of corticosteroids, with systemic administration in some cases: used for acute attacks of posterior uveitis
      v. Cytotoxic agents (azathioprine, chlorambucil, and cyclophosphamide): help prevent ocular attacks in approximately 50–75% of patients
      vi. Cyclosporine: beneficial in 70–80% of patients with ocular lesions that have been refractory to the conventional therapies
      vii. Subcutaneous human recombinant interferon alpha: an effective and fairly well tolerated therapy for Behcet disease
      viii. Results from therapies: improved vision and decreased pain, saving the individual a potential enucleation
   c. Arthritis
      i. Nonsteroidal anti-inflammatory drugs and colchicine: effective for most cases of arthritis
      ii. Low dose corticosteroids and azathioprine: used in patients whose arthritis is resistant to treatment with nonsteroidal anti-inflammatory drugs, colchicine, or Sulfasalazine
      iii. Interferon alfa: also highly effective
   d. Gastrointestinal lesions
      i. Sulfasalazine and corticosteroids: the principal drugs
      ii. Bowel rest: obligatory in patients with an acute abdomen and bleeding
      iii. Surgery: considered for patients with bowel perforation and persistent bleeding
   e. CNS lesions
      i. High doses of corticosteroids
      ii. Supplemented with cytotoxic agents
   f. Large-vessel lesions
      i. Treated with a combination of corticosteroids and cytotoxic agents
      ii. Anticoagulants and antplatelet agents: used for deep venous thrombosis
      iii. Surgery for refractory large-vessel disease

REFERENCES


Fig. 1. Aphthae on the tongue, buccal mucosa, and gums of a child with Behcet disease.

Fig. 2. A female patient with Behcet disease showing generalized scars from blisters on the buccal mucosa, trunk, arms, legs, and palms.

Fig. 3. A large aphthous ulcer on mucosal membrane of the lower lip of a patient with acute exacerbation of Behcet disease.

Fig. 4. Occluded retinal vessels and retinal hemorrhage with arterial and venous occlusive vasculitis in a patient with Behcet disease.
Bladder Exstrophy

Bladder exstrophy is a rare developmental anomaly occurring as an isolated defect in about 1/25,000–1/40,000 births.

GENETICS/BASIC DEFECTS

1. Genetics: usually an isolated defect
2. Basic defects
   a. Probably failure of fusion of the secondary mesoderm (from the primitive streak) in the midline of the anterior abdominal wall, with subsequent rupture of the thin wall consisting only of ectoderm and endoderm
   b. Early rupture (5th week) resulting in exstrophy of the cloaca, later rupture (7th week) resulting in exstrophy of the bladder

CLINICAL FEATURES

1. Classical bladder exstrophy
   a. Diagnosis easily made at birth
   b. Occur in 60% of the patients with the exstrophy-epispadias complex
   c. Bladder plate protruding just beneath the umbilical cord
   d. Posterior bladder wall is exposed through a midline abdominal wall defect
   e. Inferiorly displaced umbilicus located close to the superior margin of the exstrophic bladder
   f. Rectus muscles divergent on either side of the bladder
      i. Leading to the separated pubic bones
      ii. Separation of the pubic bones caused by an outward rotation of the innominate bones and ever- sion of the pubic rami
   g. Male patients
      i. A short epispadiac phallus with a dorsal urethral plate
         a) Caused by separation of the pubic bones
         b) Possibly caused by a true deficiency of corporal tissue
      ii. A splayed glans
      iii. Dorsal chordee
   h. Female patients
      i. Genital defect analogous to the male but more easily reconstructed
      ii. Separatedmons pubis (both hemiclitori and labia) (split clitoris and exstrophic vagina)
      iii. Predisposing to uterine prolapse, especially after pregnancy and delivery, secondary to pelvic floor defect
   i. Urinary tract abnormalities
      i. Generally normal upper urinary tract
      ii. Occasional abnormalities
         a) Unilateral renal agenesis
         b) Horseshoe kidney
         c) Hydronephrosis
         d) Other renal anomalies
   j. Internal genitalia: usually normal
   k. Fertility and childbearing
      i. Documented in both sexes but less common in the males
      ii. C-section advised to avoid injury to continence mechanism
      iii. Postpartum uterine prolapse common because of aggravation of preexisting abnormal pelvic support
   l. Inguinal hernias
      i. Incidence: very common
         a) 56–82% in boys
         b) 11–15% in girls
      ii. Incidence of bowel incarceration below one year of age: 10–53%
      iii. Causes
         a) Large internal and external inguinal rings
         b) Lack of obliquity of the inguinal canal
   m. Anus
      i. Anteriorly placed
      ii. Fecal continence adversely affected by the divergence of the pelvic musculature
   n. Rectal prolapse
      i. Virtually always disappears after bladder closure or cystectomy
      ii. Represents an indication for surgical management of the exstrophied bladder
   o. Spinal abnormalities (6.7%)
      i. Myelomeningocele
      ii. Lipomeningocele
      iii. Scimitar sacrum
      iv. Posterior laminal defects
      v. Vertebral fusion
      vi. Hemivertebrae
   p. Malignancies
      i. Rare late complication of bladder exstrophy, especially in untreated patients whose bladders are left exstrophic for many years
      ii. Types of malignancies
         a) Adenocarcinoma: the most common type, arising from the precursor cystitis glandularis, a consequence of chronic irritation and inflammation of exposed bladder mucosa
         b) Squamous cell carcinoma and rhabdomyosarcoma
         c) Adenocarcinoma developing adjacent to the ureterointestinal anastomoses in patients with urinary diversions that mix the urinary and fecal streams
         d) The risk of developing colon adenocarcinoma is increased 7000-fold after ureterosigmoidostomy among patients younger than 25 years of age than the general population
q. Behavioral, social and school competency problems observed in 70% of adolescents and 33% of school aged children
r. 70% of parents express concern about the children’s sexual function or sexual disfigurement
s. Consider all patients with exstrophy-epispadias complex to be latex-sensitive

2. Variants of exstrophy
a. Pseudo-exstrophy (exstrophic abdominal wall defect without bladder exstrophy)
b. Duplicate exstrophy
c. Superior vesical fistula and fissure
d. Covered exstrophy and visceral sequestration

DIAGNOSTIC INVESTIGATIONS
1. General assessment
2. Cardiopulmonary assessment
3. Renal ultrasound for baseline examination of the kidneys since increased bladder pressure after bladder closure can lead to hydronephrosis and upper urinary tract deterioration
4. Voiding cystourethrogram
a. To rule out bilateral vesicoureteral reflux which is present in nearly all patients with classic bladder exstrophy
b. Performed in early childhood to assess bladder capacity in preparation for continence reconstruction

GENETIC COUNSELING
1. Recurrence risk
a. Patient’s sib: the risk of recurrence of exstrophy or epispadias in a given family is one of 275 births
b. Patient’s offspring: the risk of a parent with exstrophy producing a child with exstrophy or epispadias is up to one of 70 or 500 times the risk of the general population
2. Prenatal diagnosis possible by ultrasonography
a. Absence of bladder filling in the presence of normal kidneys (bladder never demonstrated on the ultrasound) (71%)
b. A protuberance on the lower abdomen representing the exstrophied bladder (47%)
c. A diminutive penis with anteriorly displaced scrotum (57% of the males)
d. A low-set umbilical insertion (29%)
e. Abnormal widening of the iliac crests (18%)
f. Separation of the pubic rami
g. Difficulty in ascertaining the sex of the fetus
3. Management
a. Supportive management
i. Ligate umbilical cord with suture to avoid bladder mucosal damage by an umbilical clamp
ii. Protect bladder
a) With clear plastic wrap
b) Irrigate the bladder surface with sterile saline each time diaper is changed and the wrap replaced
iii. Initiate prophylactic antibiotics
b. Goals of the reconstruction of bladder exstrophy
i. Preservation of the kidney function
ii. Creation of urinary continence
iii. Reduction in the urinary tract infections
iv. Creation of functionally and cosmetically acceptable external genitalia
c. Initial bladder closure
i. Closure of the pelvic ring
a) Important for the initial closure
b) Important for the eventual attainment of urinary continence
ii. Pelvic osteotomy
a) Two main approaches: posterior iliac osteotomy and the anterior innominate osteotomy
b) Reduce the tension on the suture lines to help securing the bladder closure
c) To restore the pelvic anatomy and thus increase the chances of eventual continence and reduce the likelihood of uterine prolapse
d. Epispadias repair
i. Usually performed at 2–3 years of age before the continence procedure
ii. Contributing significantly to the development of bladder capacity
iii. Goals
a) Reconstruction of the urethra and glans penis
b) Encourage the potential of penile length
c) Correction of the dorsal chordee
d) Achieving adequate skin coverage
iv. Penis is generally reconstructible to cosmetically and functionally acceptable form, despite a short phallus
e. Bladder neck reconstruction
i. Usually performed at age of 4–5 years (when toilet training is possible)
ii. Require anti-reflux procedure since all exstrophy patients have vesicoureteral reflux
iii. Complete urinary drainage achieved with ureteral stents and suprapubic cystostomy tubes
f. Ureteral reimplantation
g. Bladder augmentation and continent diversion for patients who have failed bladder neck reconstruction and have an inadequate bladder capacity
h. Alternatives for exstrophy reconstruction
i. For patients with very small bladder plates or hydronephrosis
ii. Ureterosigmoidostomies
a) Allow children to achieve continence
b) Protect upper urinary tracts
c) Potential complications: recurrent acute and chronic pyelonephritis, urolithiasis, hyperchloremic hypokalemic metabolic acidosis, ureteral obstruction and the late development of colonic malignancy
i. Repair of inguinal hernias at the time of primary closure of bladder exstrophy

REFERENCES
Fig. 1. A newborn male with classic bladder extrophy showing low insertion of the umbilical cord, a bulging mass of extrophic bladder, and grossly abnormal external genitalia.
Body Stalk Anomaly

Body stalk anomaly, sometimes also called limb body wall complex, is a rare abdominal wall defect due to failure of the development of the body stalk. Prevalence is estimated to be 0.32 per 10,000 births.

GENETICS/BASIC DEFECTS
1. Sporadic occurrence in most cases, although concordance in twins has been reported
2. Failure in body folding in cranial, caudal and lateral axes during the embryonic stage of development
   a. Abnormalities of cranial folding leading to pentalogy of Cantrell consisting of the following:
      i. Cardiac abnormalities
      ii. Sternal cleft
      iii. Upper abdominal defect
      iv. Anterior diaphragmatic hernia
      v. Deficiency of the diaphragmatic pericardium
   b. Abnormalities of caudal folding leading to the following:
      i. Cloacal exstrophy
      ii. Hypogastric omphalocele
      iii. Imperforate anus
      iv. Partial colonic agenesis
      v. Agenesis of one umbilical artery
   c. Abnormalities of lateral folding leading to midline omphalocele
   d. Abnormalities of folding along all three axes resulting in a body stalk anomaly
      i. Failure to obliterate the extraembryonic cavity that continues to communicate with the intraembryonic cavity
      ii. Creation of a large ventral wall defect that is covered by an amnioperitoneal membrane which contains the abdominal viscera and inserts directly into the chorionic plate
      iii. The fetus appearing to be directly attached to the placenta as the umbilical cord is significantly shortened or absent
      iv. Frequent kyphoscoliosis owing to limited truncal flexion
3. Possible causes of the anomaly
   a. Early amnion rupture before obliteration of the extraembryonic coelom
   b. Abnormal splitting of the embryo at the fourth gestational week
   c. Disturbance of the blood flow due to vascular rupture, as described in cocaine users
   d. A special situation in monozygotic twins
   e. Maternal uniparental disomy of chromosome 16 in a fetus with body stalk anomaly suggesting placental insufficiency or imprinting effects as cause of this anomaly
4. Pathogenesis
   a. The umbilical cord, derived from a small mass of mesoderm (body stalk), attaches the embryo to the wall of the blastocysts
   b. Abnormal development of the body stalk resulting in an absent or rudimentary umbilical cord
   c. Consequences
      i. Direct attachment of fetus to the placenta
      ii. Abdominal viscera lying in a sac outside the abdominal cavity covered by amnion

CLINICAL FEATURES
1. A large anterior abdominal wall defect with a large omphalocele
   a. Outside the abdominal cavity containing thoracic and/or abdominal organs
   b. Covered by amnion
   c. Appears continuous with (adherent to) the placental membranes
2. Absent, rudimentary, or extremely short umbilical cord. A severe type of short umbilical cord syndrome may be a variant of the body stalk anomaly
3. Two-vessel cord
4. Severe kyphoscoliosis
5. Placenta directly attached to the amnioperitoneal sac
6. Extensive associated anomalies
   a. Hypoplasia of the lungs
   b. Anal atresia (imperforate anus)
   c. Agenesis of the colon
   d. Intestinal atresia
   e. Exstrophy of the cloaca
   f. Vaginal atresia
   g. Agenesis of uterus and gonads
   h. Absence of external genitalia
   i. Hypoplastic kidneys
   j. Absence of diaphragm
   k. Diaphragmatic hernia
   l. Spina bifida
   m. Dysplastic thorax
   n. Occasional coexistence of the syndrome with limb malformations (mostly lower extremities) and amniotic bands
7. Fetal death caused by abruptio placentae
8. Liveborn infant die shortly afterward

DIAGNOSTIC INVESTIGATIONS
1. Radiography to document skeletal anomalies
2. Cytogenetic analysis
   a. No specific anomaly
   b. Placental karyotyping: report of a case with placental trisomy 16 and maternal uniparental disomy (UPD)
GENETIC COUNSELING

1. Recurrence risk
   a. Patient’s sib: not increased
   b. Patient’s offspring: not surviving to reproductive age

2. Prenatal diagnosis
   a. High maternal serum alpha fetoprotein
   b. Ultrasonography
      i. Can be diagnosed as early as the first trimester by transvaginal sonography
      ii. A large abdominal anterior wall defect with abdominal organs in a sac outside the abdominal cavity in apparent continuity with (adherent to) the placental membranes
      iii. An extremely short or absent umbilical cord
   c. Amniocentesis
      i. Elevated amniotic fluid alpha feto-protein level
      ii. Abnormal acetylcholinesterase
      iii. Normal chromosomes

3. Management: newborn with the body stalk anomaly, uniformly fatal

REFERENCES

Fig. 1. An extremely premature neonate with body stalk anomaly. Short umbilical cord (7.5 cm with 5 cm fused with placenta) and a large amnioperitoneal sac between the abdomen and the placenta are evident. The sac was filled with internal viscera. In addition, there were anal and urethral atresia, rectovesical fistula, left renal agenesis, lumbosacral meningomyelocele, severe scoliosis, and lumbosacral hypoplasia.

Fig. 2. An infant with body stalk anomaly showing Potter facies, severe kyphoscoliosis, and a large amnioperitoneal sac outside the body. The sac contained abdominal organs. The umbilical cord was absent. Limb and vertebral defects illustrated in the radiographs.
Fig. 3. Another infant with body stalk anomaly showing anterior abdominal wall defect with a large sac containing abdominal organs, exstrophy of the bladder, and clubfeet.
Branchial Cleft Anomalies

Abnormal persistence of branchial apparatus remnants results in branchial anomalies.

GENETICS/BASIC DEFECTS
1. Embryology of the fetal branchial apparatus
   a. A derivative of a foregut, developed during the second fetal week
   b. Consisting of five paired pharyngeal arches, separated internally by four endodermal pouches and externally by four ectodermal clefts
2. Embryology of the branchial clefts
   a. First branchial cleft
      i. Giving rise to the Eustachian tube, tympanic cavity, and mastoid antrum
      ii. Contributing to the formation of the tympanic membrane
      iii. The only cleft to contribute to the adult structure is the external auditory canal.
   b. Second, third, and fourth branchial clefts
      i. Known as the cervical sinus of His (part of an ectodermally lined depression)
      ii. Obliteration of the cervical sinus as the second and fifth branchial clefts merge
   c. Second branchial pouch
      i. Lined by ectoderm
      ii. Contributing to the palatine tonsil and tonsillar fossa
   d. Third branchial pouch: forming the following structures
      i. Inferior parathyroid gland
      ii. Thymus
      iii. Pyriform sinus
   e. Fourth branchial pouch: forming the following structures
      i. Superior parathyroid gland
      ii. Apex of the pyriform sinus
3. Pathogenesis of branchial cleft anomalies: remains controversial
   a. Arising from incomplete obliteration of the cervical sinus of His
   b. Arising from buried epithelial cell rests
4. Genetics: autosomal dominant inheritance in some families

CLINICAL FEATURES (KOELLER, 1999)
1. Manifestation of branchial cleft anomalies
   a. Cyst
      i. An epithelial-lined structure without an external opening
      ii. Most common branchial cleft anomalies (75%)
   b. Sinus
      i. A blind tract with an opening externally through the skin on the side of the neck representing persistence of a branchial groove
      ii. A blind tract with an opening internally into the foregut representing persistence of a branchial pouch
   c. Fistula
      i. A tract communicating between the skin externally (a patent abnormal canal opening externally on the neck surface) and the foregut internally (within the pharyngeal mucosa)
      ii. Representing persistence of a branchial groove with its corresponding pouch and without branchial membrane between them
   d. Skin tag: a branchial remnant presenting in the lateral neck
   e. Bilateral branchial cleft anomalies
      i. Occurring in 2–3% of cases
      ii. Often familial
2. First branchial cleft cyst
   a. Accounting for only 5–8% of all branchial cleft defects
   b. Most commonly seen in middle-aged women
   c. Usually manifesting as recurrent abscesses or other inflammation (sinus tract) either around the ear or at the angle of the mandible
   d. History of recurrent parotid abscesses unresponsive to antibiotics and drainage
   e. Cystic drainage into the external auditory canal
      i. Aural fistulas
      ii. Auricular swelling
      iii. Otitis
      iv. Otorrhea
      v. A cervical skin tag at birth
   f. Occasional sinus tract extending to the hyoid bone
   g. Cyst related to the parotid gland
      i. Forming abscess and produce parotitis
      ii. May be associated with facial nerve palsy
3. Second branchial cleft cyst
   a. Most common developmental anomalies arising from the branchial apparatus
   b. Cysts
      i. Accounting for at least three-fourths of branchial cleft anomalies
      ii. Typically occurring between 10 and 40 years of age
   c. Location of the cysts
      i. Most commonly in the submandibular space
      ii. Anywhere along a line from the oropharyngeal tonsillar fossa to the supraclavicular region of the neck
   d. Signs and symptoms of second branchial cleft cyst
      i. Usually appearing as painless, fluctuant masses in the lateral portion of the neck adjacent to the
antomedial border of the sternocleidomastoid muscle at the mandibular angle

ii. Enlarge slowly over time

iii. Painful and tender if secondarily infected

iv. Highly suggestive in a young patient with a history of recurrent inflammation in the region of the mandibular angle

v. Ostium usually noted at birth just above the clavicle in the anterior neck if a fistula is present

e. Fistulas and sinuses

i. Almost always present at birth

ii. With a small pinpoint external opening

iii. May go unnoticed for years if there is no drainage

iv. Symptoms consisting of continuous or intermittent mucoid drainage and recurrent attacks of inflammation that often follow mild trauma or an infection of the upper respiratory tract

v. Occasional formation of cellulitis and abscess

vi. Probing of the track producing irritation of the vagus nerve

vii. Usually unilateral

viii. Found in several members of the same family

4. Third branchial cleft cyst

a. Extremely rare

b. Most cysts located in the posterior cervical space posterior to the sternocleidomastoid muscle

c. Constituting the second most common congenital lesion of the posterior cervical space of the neck after cystic hygroma

d. Usually manifesting as a painless, fluctuant mass in the posterior triangle area of the neck

e. Mass usually distending during a viral infection of the upper respiratory tract

5. Fourth branchial cleft cyst

a. Extremely rare

b. Usually manifesting as a sinus tract rather than a cyst or fistula

c. Majority of the lesions occurring on the left side

DIAGNOSTIC INVESTIGATIONS

1. CT scans/MRI imagings

a. First branchial cleft cyst

i. Appearing as a cystic mass either within, superficial to, or deep to the parotid gland

ii. Variable wall thickness and enhancement: increase with recurrent infections

iii. Difficult to differentiate from other cystic mass of the parotid gland

b. Second branchial cleft cyst

i. Typically well-circumscribed, homogeneously hypoattenuated masses surrounded by a uniformly thin wall

ii. Increased mural thickness after infection

iii. “Beaked sign” (a curved rim of tissue or “beak” pointing medially between the internal and external carotid arteries) considered a pathognomonic imaging feature of a second branchial cleft cyst

c. Third branchial cleft cyst

i. Most commonly appearing as a unilocular cystic mass centered in the posterior cervical space

ii. Cyst fluid varying in signal intensity on T1-weighted images depending on the protein concentration and is typically hyperintense relative to muscle on T2-weighted images

d. Fourth branchial cleft cysts

i. Connected with the pyriform sinus

ii. Appearing similar to an external or mixed laryngocele

2. Ultrasonography

a. A fluctuant, compressible, anechoic or hypoechoic mass

b. May have fine internal debris

3. Sinogram or fistulogram with radiopaque dye

a. To help confirming the diagnosis

b. To identify length and location of the fistulous tract

c. To identify an associated cyst

GENETIC COUNSELING

1. Recurrence risk

a. Patient’s sib

i. Not increased in de novo case

ii. 50% recurrence risk if a parent is affected with an autosomal dominant disorder

b. Patient’s offspring: 50% in autosomal dominant inheritance

2. Prenatal diagnosis by ultrasonography possible by demonstrating a cystic neck mass in the fetus with differential diagnosis including hemangioma, dermoid cyst, neuroblastoma, congenital cystic hygroma, teratoma, epignathus, esophageal duplication, goiter, and laryngocele

3. Management

a. First branchial cleft cyst: complete surgical excision (only curative therapy)

b. Second and third branchial cleft cysts: surgical excision recommended because of increased frequency of secondary infection

c. Recurrence risk uncommon after surgical excision

d. Antibiotics required for treating infections or abscess

REFERENCES


Fig. 1. A branchial cleft cyst in the left side of the neck.